Special Commission on the Health Care Payment System
Commission Meeting Minutes: March 13, 2009

Date: Friday, March 13, 2009
Time: 11:00am – 2:00 pm
Place: One Ashburton Place, Boston

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane (by telephone) ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Melissa Thuma, attending on behalf of Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Deborah Chollet, Mathematica Policy Research, Inc. ✓ Ann Robinow, presenting on the Patient Choice Health Care Payment Model in Minnesota ✓ Patrick Gilligan, Senior VP, BCBSMA ✓ Dana Safran, Senior VP, BCBSMA	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Deborah Chollet, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC

Meeting Minutes

I. Welcome and Overview

Co-Chair Leslie Kirwan introduced Melissa Thuma, attending on behalf of Representative Stanley, and noted that Nancy Kane was joining by telephone. Ms. Kirwan explained that she recently spent a week in the hospital. During her stay, she gained a different perspective on the health care system and its related needs. She also reported that as chair of the Commonwealth Connector Board she is pleased to report that premium costs will be decreasing for the average member of Commonwealth Care. She sees this as a victory for both the Commonwealth and for all enrollees. It is an important step in sustainability. She does not want this fact to be overshadowed by some politics around the Connector accepting a new Commonwealth Care vendor.

Co-Chair Sarah Iselin reminded the Commission members that this is the last of the learning meetings. The topics for today's meeting will be global budgets and global payments. Deborah Chollet will be providing an overview and she will be followed by two case studies: BCBSMA's Alternative Quality Contract and Minnesota's Patient Choice Program. She also explained that the Commission would be reconvening in a few weeks to begin the process of developing recommendations.

II. Revised Principles – Michael Bailit

Michael Bailit reported that since the last Commission meeting he distributed a set of revised principles and received feedback from half of the Commission members. The set of principles he is distributing at this meeting incorporates most of the feedback he has received, and reflects a comprehensive discussion. He explained that as a result the principles are longer, about which several Commissioners expressed regret. He noted that the principles would now serve as a tool to evaluate payment models.

He explained that there are three rounds of stakeholder meetings as part of this process. He will be holding the second round next week during which he will be explicitly requesting recommendations regarding payment strategies. He will be sharing the results of his meetings at the April 3rd Commission meeting.

III. Overview of Global Payments – Deborah Chollet

Global payments are payments bundled at the patient level and include all services over a time period, usually a year. Payment covers all services required by the patient over the contract period or for a set of covered services. The key to understanding global payments is the extent to which providers are put at risk. They are put at risk for the occurrence of services needed, for the amount of services provided and for the cost of services provided. Providers are incented to provide services efficiently. There are no incentives to over provide care or to raise rates. Therefore, the source of risk is the occurrence of services needed. Plans have developed ways to limit provider risk, often in response to state regulators.

The intended provider incentives are to:
- Contain costs by reducing use of unnecessary services.
- Encourage efficient integration and coordination of health care services.
- Potentially improve quality via coordination of care.

Because providers get reimbursed a flat amount, there are some inherent incentives to integrate care efficiently. History has shown that without that type of integration, it is difficult to control costs. Providers can be induced to respond efficiently with an overlay of direct quality incentives, such as pay-for-performance.

Global payments may also incent providers to avoid predictably high-cost patients. If the provider has a high-cost patient, the provider won't make the necessary margin. There is no evidence that providers actually avoid these high-cost patients.

Global payments also provide incentives for providers to consolidate into larger organizations to offset the impact of an unusually high-cost patient.

Evidence regarding the impact of global payment on health care is inconclusive, since most studies, which occurred in the 1980s and 1990s, were disjointed, opportunistic, used different research methods, and did not corroborate one another. No researcher found any huge negative impact, but long-term impacts are not known. There is anecdotal evidence that provider organizations could not integrate services across settings sufficiently to control costs.

In the early 1990s, the National Association of Insurance Commissioners (NAIC) developed an advisory that if providers were the primary risk holders, they needed reserves and to respond to the rules of the state insurance regulators. This generated considerable controversy. California has the most comprehensive legislation, requiring providers to disclose their financial condition to insurers and to the Insurance Commissioners. Carriers can hold reserves for providers to allow them to bear risk under a global capitation.

Carriers have developed several ways to reduce provider risk, including:
- Risk adjusted payments, in which the payment rate is varied for patient characteristics. There would be higher payments for older patients, and patients with known diagnoses. This addresses issues of patient dumping and the under-reserve issue.

- Blended capitation, which allows for local variation in cost and provider practices. Under this methodology, the state would set capitation and allow for different rates for different geographies. It gives systems a place to start.

Once the risk has occurred, insurers use the following approaches to limit risk:

- Stop loss shifts the risk back to the carriers when costs exceed a certain level. This can be set either at the patient level or the total practice level. This approach has certain efficiencies in that once the patient costs are over the attachment point, there is a need for review by the carrier.
- Reinsurance reduces provider loss, but providers usually retain a percentage of total costs.
- Partial capitation, which is a global payment only for more predictable services such as primary care. The provider remains at risk for service need and cost of care.
- Risk corridors limit providers' upside and downside risk. Under this system the carrier assumes liability for high-risk costs, but also gets the benefit if costs are low. CMS uses risk corridors in Medicare Advantage contracts.

Methods of limiting provider risk are complex to develop and update. They must be updated constantly and need lots of data. Incentives to maintain and improve quality and efficiency are also complex to develop and administer. Embedded in blended capitation rates are cost and practice targets. Quality incentives are indirect. It is possible to have a blended capitation to reduce disparity, but a quality incentive is usually overlaid.

Commissioners' Questions and Comments:

Question and Comments	**Speaker's Response**
Are there studies showing that providers receiving a global payment do not avoid the high-cost patients.	None of the research looking at this question has found any evidence of high-cost patient avoidance or dumping. Most patients have employer-based contracts which provide little opportunity to dump.
The issue for individuals without employer coverage is obtaining access to care.	If the coverage is individually based, dumping may be a problem.
Under a blended capitation are there any prioritizations based on specialties?	None that I know of.
In the past global capitations have resulted in a continuous ratcheting down of payments as savings come out of the system to the point that there are no incentives for providers to participate. Does there get to be a point of equilibrium?	This end game has not emerged in California. My speculation is that this is because Kaiser establishes a price level around which other providers compete. This staff model competes on the basis of quality, so there is some quality competition also. When independent physician practices are trying to coordinate care, it does not work as well, so there is more incentive to ratchet down rates because price becomes the only currency for competing.
Given the limits of research, how successful is primary-care-only capitation or some mix that is less than a global cap.	Probably the largest capitation systems are state Medicaid programs. Most have a partial cap for primary care for mothers and children. Most think that it works, but I am not aware of any evaluation assessing where do you draw the line (as to what is included under the cap). States have used capitation for a relatively

Question and Comments	Speaker's Response
	healthy population, but have consistently carved out mental health. For a more diverse population and for more people, it is untested where you would draw the line. There are renegotiations every year as the world changes and providers become more sophisticated.
In a way medical home variations are essentially suggesting a partial cap. When there is no risk for those receiving a capitation payment, you may have services and dollars going out of the capitation. How you create balance is complex and critical.	Michael Bailit: Most medical homes are built on fee for service. Deborah: global payments are satisfactory for those used to accepting risk. When applied to small group practices, it is more difficult. You need a multi-specialty practice with strong control of the hospital.
In California the average number of physicians in a practice is in the 300s; three-quarter of practices are over 50. It is a very different than how Massachusetts is structured.	California is a mature system. The consolidation happened as the system grew up with global payments. Global payments force providers to join into multi-disciplinary systems. The less there is of global caps, the less are the incentives to combine.
There is also a different culture in California. Kaiser has been there so long that they set the benchmark. There are different patient expectations here. Outside of Rt.128, the largest group is 15 to 20 members. We don't have large groups able to accept a global capitation.	
More than half of our payments go to seven groups in Massachusetts. There is a lot more consolidation than some people think. Some of the early pioneers are modest sized groups in Western Massachusetts. I caution the group about jumping to conclusions about California from a decade ago. "Global capitation encourages accountability regarding quality and efficiency" is as much the message "as global capitation puts providers at risk."	
We are working on a homework assignment around what the Massachusetts system looks like: MD groups by size, payment volume by type of reimbursement, highest prevalent procedures and conditions, and hospital affiliations.	
Is it possible to have a trend line regarding practice size.	

IV. BCBSMA Case Study – Patrick Gilligan and Dana Gelb Safran

Andrew Dreyfus framed the initiative by explaining that three years ago BCBSMA launched a 10-year initiative to transform health care in MA with the goal of everyone having safe, effective care. BCBSMA also is promoting HIT with its participation in the e-prescribing collaborative. They also have an

initiative with the Massachusetts Hospital Association to educate hospital trustees about quality. BCBSMA is also working with a collaborative regarding quality measures, and supports five pioneering practices to accelerate transformation. These efforts are being undertaken in response to demands from employers to cut costs and improve quality and from providers and hospitals that are saying that fee-for-service does not work because it is an open invitation to health plans to manage costs and quality of care. Providers recognize that they need to be better regarding efficiency and quality.

The result of these efforts is a new contract. A year ago there was skepticism in the provider community about assuming more risk under this contract. In the last six months there has been increased enthusiasm because providers see a blended payment methodology as the future. Those that can accept this risk now will be more successful in the future. BCBSMA recognizes blended capitation as an answer, rather than the answer.

Patrick Gilligan, Senior Vice President, Health Care Services explained the key components of the new payment model as follows. The Alternative Quality Contract model is composed of key components that are standard across provider entities:

- Integration across the continuum of care.
- Accountability for performance measures (ambulatory and inpatient).
- Global payment for all medical services (health status adjusted).
- Sustained partnerships through execution of a 5-year contract.

The contract elements reward and support integration. Ideally, BCBSMA wants the PCP, specialists and hospital to accept the risk. Sometimes only a multi-specialty group without the hospital will be the risk-bearing entity. There is a group in Western Massachusetts with 46 physicians and no hospital that is doing very well under this arrangement. The model can accommodate global payment by making monthly cash payments, which the entity distributes, or it can pay FFS in the interim with a year-end settlement. The five-year contract with budgets set in advance makes a huge difference because time is not spent on continually negotiating. The contract will eventually cover all BCBSMA product offerings.

The model works by setting budgets for a five-year period of time. The starting budget is based on historical costs. In the 1990s the budgets were starved and started too low. BCBSMA is working to set budgets correctly. The model recognizes inflation by using CPI, and not historical medical inflation. BCBSMA believes that there are enough dollars in the system. BCBSMA is trying to reduce the rate of increase over five years. There is also a significant upside bonus on quality measures. BCBSMA holds providers accountable for cost and quality with quality-based incentives up to 10% of the overall budget. The global capitation is adjusted annually for changes in health status of the covered population. It is diagnoses based, not procedure based, which BCBSMA thinks is a reasonable way to address the sick patient problem.

BCBSMA is willing to share risk, if the providers are not ready to accept full risk. BCBSMA wants providers to take total capitation, but recognizes that providers might have different infrastructure costs. They can use the budget to pay these costs. The budget also needs to cover the costs of risk management. If an entity wants stop loss, BCBSMA can provide it for a cost or they may go onto the open market. Blue Cross can also provide total aggregate risk, so that if the provider wants this protection, they can purchase it.

This payment model differs from capitation in the following ways:

- There is a significant upside potential based on a sophisticated set of measures that address patient safety, appropriateness of care and patient satisfaction. This is the biggest difference.
- The initial payment level is derived from the historical experience of the provider group.

- Payment is adjusted annually in line with CPI. Providers can retain margins derived from reduction of inefficiencies.
- Payment is health status adjusted to adequately consider changes in patient morbidity.

Dana Gelb Safran, Vice President, Health Care Services, explained the model's quality measures as follows. Measures should collectively advance care such that it is affordable, effective and patient-centered. Clinical performance measures will include process, outcome and patient care experience measures. They will encompass inpatient and ambulatory care.

The provider's performance is evaluated in terms of thresholds (or "gates") that are defined in absolute terms, rather than in relative terms. Using relative measurements would result in winners and losers, which is antithetical to BCBSMA's goals. The vision is that the absolute thresholds define good performance and the outer limit captures what is possible to achieve. Where the provider performs with respect to the gates, will determine its level of incentive payments. The contract states targets for the 5-year period of the contract and are structured to incent continued improvement. The use of gates affords "transparency" to providers regarding the full scope of BCBSMA's performance priorities and expectations.

BCBSMA is using national measures from such sources as HEDIS and JACHO. For each measure BCBSMA sets Gate 1 through Gate 5. Providers coming into this payment model are taking on the responsibility for outcomes. BCBSMA has triple weighted some measures at the request of early provider participants (diabetes measures, hypertension and cardiovascular disease). Providers cannot be successful under this model without recognizing the importance of primary care. The contract provides the opportunity to develop several new measures, in acknowledgement of the rapidly changing field of quality. BCBSMA has created a mechanism to create new measures. Mt Auburn providers who were seeing a large number of patients being discharged without their lab results suggested the first new measure. They are developing a way to get lab results at the time of discharge. This is changing the dialog between carriers and providers.

The quality payments providers receive depend on what level the provider is performing. The payout curve rewards early and middle improvement with less increase between gates four and five.

Commissioner Questions and Comments:

Question and Comments	Speaker's Response
Is behavioral health and pharmacy included under the capitation?	The preferred model includes both. To date we have carved out behavioral health. Pharmacy is included in all contracts and pharmacy benefits are operated through our PBM.
If you are a patient, are you assigned an HMO?	We are applying this currently only to HMO products. The global dollars are linked to providers through the member picking a PCP. The patient will not know that the provider is participating in this new payment model. Providers want more transparency about participating in this type of program. Currently Harvard Vanguard does its own patient education. BCBSMA is willing to help.
When the HMO movement started, it was like a religion and the physicians were true believers.	BCBSMA is talking about what it can do to support more transparency. We believe that

Question and Comments	Speaker's Response
The secondary wave of enrollees hadn't signed up for the religion and when they found out about limits, they got angry. Patient awareness of what they are signing up for is critical.	the movement to push more cost onto the patients is close to its limit. If patients are offered a choice of a more costly or more restrictive system for less cost where we can show that care is as good as or better than the high deductible plan, we believe many patients will select the more restrictive plan. We need to have a different type of conversation and we need to be open.
How is risk management included in the budget?	The historical budget and trend includes risk management costs.
Is the budget risk adjusted on an individual or panel basis?	It is adjusted on a panel basis.
Why would an entity not want to take stop loss?	All entities take some level of specific stop loss coverage. They may not want aggregate coverage if they are very large and experienced in managing care.
Is there some minimum requirement for stop loss built in?	We won't sign a contract if a certain sized group does not have stop loss coverage.
If a physician group is signing up with a particular hospital to share risk, how does it work if the physician uses different facilities for different services.	BCBSMA says that you can go to anyone in the provider network. We need to move to a different education for patients. We say that you need a physician referral and we need to support that physician's choice. Andrew Dreyfus: The cost of patients going to other facilities than the risk-sharing facility is built into the historical costs, so the entity is not hurt. There is an incentive to keep the care within the integrated group.
How does claims processing work.	If its a global budget, BCBSMA pays claims and reports back with a year-end settlement. If it is a global payment, BCBSMA will do an estimate of the funds that will stay within the provider system and pay that amount out monthly. We will keep the remaining amount to pay for out of risk-bearing entity claims.
Because BCBSMA is large it has the advantage of a huge data base to create statistically sound measurements. How does use of absolute benchmarks address variability of performance?	BCBSMA has relied on national or statewide data, data sets available to all, to create our gates. It is important that the highest gate is a stable number that shows up anywhere in the US. We are only using quality data.
What kinds of patients are in your groups.	No answer.
Can this model be expanded to the PPO products, since the HMO enrollment is shrinking?	Yes. The problem is that the PPO does not require members to select a PCP. We know that the vast majority of Americans have PCPs. We have an attribution model that is similar to other models (93% of PCP-member matches were correct). There will always be a segment of the population not receiving care, but in the

Question and Comments	Speaker's Response
	system. We are working on figuring out how to deal with this segment, and hope to solve the problem in the next year or two.
When and how do employers benefit from this process?	The employers benefit by having a lower rate of inflation. Even if trend savings are offset by quality payments, there will still be savings from improved health.
We need cost savings. CPI plus (in costs) may still be more than we can afford.	We believe that there is 30% waste in the system. We believe that our model starts to get that reduced. Andrew Dreyfus: BCBSMA has struggled with the question of to whom should the benefit accrue. Our model will cut the trend in half over five years. Employers want to know when it will get to zero. We believe that if physicians and hospitals work collaboratively, we will create an inflection point at which the system will change. There are also opportunities in benefit design to direct members to high value services, which may produce additional savings.
Can the model be effective if it did not start at the current budget amount?	If we want to pay for integration, then we need to provide incentives to integrate.
Some people talk about taking funding out of the system; other focus on improving quality. I look at the end point to be to pay the same percent of GDP, but get better outcomes and less disparity. This is targeted at getting more value out of the system, even if the trajectory does not go backwards.	
The obligation of the Commission is to think about helping the Commonwealth (save money) in the relative short term. Remember what happened at Virginia Mason in the West Coast – they reduced costs, but the hospital lost revenue, so the initiative was stopped. We must be intellectually honest that there will be losers and winners. If we don't face up to this, we will have mushy recommendations that won't be responsive. We won't make everyone happy.	The incentives in our model have engaged providers to be involved in what gets into the system. We know that part of the reasons for the increased costs is because of new treatments and technologies because there is no way to say no. Traditionally there are no incentives to say no. The BCBSMA model changes the dynamics of the discussion.

V. Case Study of Global Payment – Patient Choice: Ann Robinow

The Patient Choice initiative was started in Minnesota in 1995 on behalf of the Buyers Health Care Action Group (BHCAG). It went live in 1997 and is still operating. It was spun off into Patient Choice in 2001 and sold to Medica, a large HMO, in 2004.

The objective of Patient Choice is to use market forces and a new approach to provider payments to force providers to compete by managing costs and improving quality, and by giving consumers incentives and

tools to migrate to better performing providers. This was possible in Minnesota because there are several discrete primary care provider systems with only some overlap at the specialty level.

We felt capitation was a non-starter, but wanted global payment incentives. Critical to the incentive was having external market discipline from consumers, otherwise provider would just use clout to maximize global payment amounts.

The new approach to payment needed to:

- Make providers accountable for total population costs.
- Work with a variety of different provider structures. We were working with a predominance of highly integrated systems, but also with a mix of provider configurations.
- Work with a variety of plan designs, including high deductible plans.
- Minimize infrastructure needs and changes.

The program works by having providers organize into systems, which are measured on cost and quality. Providers submit bids based on their expected total costs of care for like patient populations with the same benefit set. Patient Choice created the utilization information by taking data and feeding it into a computer-based model to create historic provider utilization information.

We calculated the total cost of care, and then risk adjusted payments based on patient population, using a standard set of benefits. This created a claim target, which was adjusted based on quality measures. We compared claim targets and created claims bands. We then disseminated information on quality and system capabilities and worked with the employers to create premium bands. The range was enormous. Consumers could then choose to join a provider system based on value. There was transparency of information on care system costs and quality to patients and to payers. Consumer premium and benefit incentives were established by employers to spur choice of better performing providers. Employers were urged to contribute at the level of the least expensive system.

We used a variable FFS payment approach. Claims were paid on a FFS basis at the submitted prices. Quarterly, we calculated total costs of care using the submitted pricing based on 12 months of history. We compared these costs against the claim target. We then increased or decreased fees based on where the actual costs were compared to the claim target. We did not collect or dispense retroactive payments. Annually we redid the bidding process with a new claims target set, and cost bands created. Consumers then picked their system.

Providers organized into care systems and self defined their referral and hospital networks. Providers created their own brand and market position by demonstrating value to constituents. They could be a gatekeeper or open-access model; they could focus on specific populations or regions; they could set their own price and contract externally for services and they could control their care decisions. For example, providers could use the funds to pay for non-traditional care, such as phone visits.

Our evaluation shows that enrollees have migrated to better performing systems over time.

This system differs from capitation in the following ways:

- Every service is reimbursed.
- Providers do not receive a pool of dollars prospectively.
- Providers do not distribute dollars, but the claims payer does.
- Performance impacts future fee levels and presentation to consumers; there is no retrospective impact.
- Providers cannot run out of dollars or pocket excess dollars, so there is no windfall or loss of funds.

- Avoiding sick patients is counterproductive because they drive more revenue; the incentive is to attract sick patients and manage them well.
- Consolidating for higher payments (through use of clout) is counterproductive.
- Performance evaluations are risk adjusted.
- The model can be used for self--funded employers with any benefit style, because of the variable FFS.

Patient Choice's key accomplishments are the following:

- Got providers to organize themselves into mostly discrete systems.
- Got providers to be accountable to global budgets without bloodshed.
- Got providers to feel accountable to their patients rather than to health plan executives to explain their high costs to patients.
- Allowed employees to continue to access higher cost systems, but at a price.
- Enabled cost conscious employees to lower their costs, which is not possible in a traditional arrangement.

Barriers not solved by Patient Choice include:

- We never got a critical mass of patients needed to drive substantive change, especially in provider investment strategies.
- Employers were reluctant to hold employees accountable for their choices. They did not want employees to bear the actuarial cost differences, and were nervous about the cost to employees of buying up to a higher cost plan.
- A number of employers who were large national accounts were reluctant to do anything different in a single market.
- There was resistance to change at every level. In particular, employers and plans did not like change, although many consumers were comfortable with change.

The lessons learned include:

- Change is really hard, but possible.
- Providers can be accurately differentiated and stratified.
- Lower prices do not necessarily mean lower costs.
- Consumers will respond to financial and quality variation.
- One can build on the current FFS system using existing claim systems to drive appropriate resource use.
- Smaller provider entities can participate if they are not subject to insurance, but still accountable for total care of their patients.
- Data integrity is crucial to the process and to get buy-in. We had some bumps along the way.
- Change requires strong administrative capabilities.
- Change creates winners and losers and losers will undermine the process, while good performers like it.
- You need a critical mass to drive provider investments, but just leveraging variation can create savings.
- Patient Choice is harder to explain and sell than standard products.

In asking the question whether a model like Patient Choice could be done in Massachusetts, Ann offered the following observations:

- National employers are looking for all-at-once national solutions. This model requires local attention and provider interaction. It cannot be dropped wholesale on the entire country.

- It is easiest to implement in markets with some degree of physician organization, verses solo or very small practices. Solo practices need some degree of vertical organization.
- This model can be modified for smaller, less organized markets by banding provider types (PCPs, specialists and hospitals) separately.
- It can bridge and combine with more granular approaches to reimbursement, such as episodes of care payments. Episodes of care payments must be done within a total over-all cost target or limit.
- Plans within the target market must create similar products.
- This model may work best in an individual market, rather than in a group market, since employees are open to change more than employers are.
- Current market conditions are creating renewed interest in this type of solution. I am referring specifically to the Minnesota health reform legislation. There is also some national interest in the Patient Choice model.

Commissioner Questions and Comments:

Question and Comments	Speaker's Response
Are there any minimum requirements for provider IT infrastructure?	There were no requirements. We look at the providers' ability to manage through the continuum of care. There was only one entity that could not meet the request, which was the U of Minnesota Medical Center. They made changes and joined later.
How did you deal with rural areas when patients can't chose because there are no other doctors available or are not taking more patients.	We did not see this as a problem. All people had insurance and were desirable patients. For rural providers, we still calculated all information and used the same approach. Rural employers used their relationship with providers to show them that they were not performing at levels expected and insisting that patients be sent to other specialists. This had an impact. It is not as effective as real competition, but it was an important influence.
What did you do when tertiary hospitals are buying practices and incentivizing PCPs to send patients to tertiary hospitals?	Under this model, the system still had to prove that sending patients to premium providers was resulting in value. We saw high cost systems lower their costs.
Wouldn't consolidation eliminate competition?	Providers organized more around optimizing resources, rather than to gain clout. The consolidated systems were not the best performers. Small PCP groups that could turn on a dime regarding where to admit or which specialists to use were most successful. Integrated systems can have lots of overhead.

How does this model look to consumers?	Most employers would charge a premium based on the cost of the system. Some employers varied co-pays based on cost of the system. We wanted to have the actuarial value to be reflected in what consumers paid, which is easier to do with premiums than with co-pays. We did not see a correlation between price and quality. We believe that the total cost of care (resource use) is a quality measure.
What was your market share? What is BCBSMA's market share?	Market share was 10% initially. It then shrunk as insurers bought back clients. Patrick Gilligan: BCBSMA's market share is 25% on average. To implement change, you still need a larger chunk of the market, including Medicare and Medicaid.
Was the total cost trending down?	Trend was about 2% lower than market trend. The migration to lower cost providers was the reason for the lower trend.
When I was part of the Massachusetts Health Care Purchasers Group we tried to promote Patient Choice in Massachusetts. Providers and plans were against it and we could not get any traction. Change was terrifying and they could not come to grips with the idea of disrupting the existing system. I think that timing is better for change now – the status quo is not working.	I suggest that you work through plans to get traction with providers and employers. In Minnesota, provider organizations are recognizing just in the last month or two that "the jig is up" and are starting to make their own changes.
What was the plan landscape in Minnesota when you rolled this out?	We had three dominant not-for-profit plans that saw this as competition. Part of our problem was timing. Consumer Driven Health Plans were coming out and Patient Choice was more difficult to explain.
Were practices involved in serving employer-based patients?	Patient Choice was for self-insured employers. The State of Minnesota runs a similar program successfully. This has not been implemented with Medicaid. You would need to be more creative regarding incentives if it were to be implemented for Medicaid.

VI. Overview of Global Budgets – Deborah Chollet

Deborah Chollet presented the following information regarding global budgets.

A global budget places a maximum on total expenditures made by some or all payers. Global budgets apply to a defined set of services and are intended to limit total expenditures for care. There are several system-wide examples. Canada and the UK set global budgets at the government level. In the U.S. Medicaid and SCHIP block grants are global budgets; the VA services are provided under a global budget and the Medicare sustainable growth rate targets are global budgets that Congress does not sustain.

There are no direct incentives. Incentives vary with "flow down" provider payment provisions. In practice, experience suggests that global budgets reduce or slow delivery of services, which if waste is not a bad thing. They also create longer queues or waiting periods for non-emergency services. Managing queues is a very important issue.

Planning and operating a global budget implies that there will be regulation of provider payment and/or premiums. Regulation is direct if associated with payments. Payers have little experience managing this flow down. There must be systems of monitoring and measuring cost in real time. Last years dollars are not good enough. Canada and the UK own the assets so the costs are known. There must be an ability to manage patient queues without adverse impacts or outcomes. Finally, there must be sustained political will. The system requires predictability. There must be some distance between decisions and politics. There needs to be an independent or quasi-independent board to administer the system.

Question and Comments	Speaker's Response
Conventional wisdom regarding global budgets is that people have to wait long periods to get needed care.	One must distinguish between emergency and elective services. Emergency services will be provided without queues.
Is Patient Choice an episode of care model?	It is a global budget that impacts fee-for-service levels.

The meeting ended at 2:00pm.